STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005846	A. BUILDING _____ B. WING _____	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENTRY MEADOWS ASSISTED LIVING	7833 W JEFFERSON BLVD FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey date: December 19, 2012 Facility number: 005846 Provider number: 005846 AIM number: N/A Survey team: Virginia Terveer, RN-TC Sue Brooker, RD Julie Call, RN Angela Strass, RN Census bed type: Residential: 71 Total: 71 Census payor type: Other: 71 Total: 71 Sample: 8 Coventry Meadows Assisted Living was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey. Quality Review completed on 12/20/12 by Randy Fry RN.	R 000		